The Nursing Strategy for Canada

October 2000

Advisory Committee on Health Human Resources

In September 1999, the federal/provincial/territorial Ministers of Health directed the Advisory Committee on Health Human Resources (ACHHR) to prepare options for consideration to strengthen health human resources development. The ACHHR's mandate is to provide policy development and policy advice on health human resource issues to the Conference of Deputy Ministers of Health.

As part of this work, the ACHHR Working Group on Nursing Resources, in consultation with nursing stakeholders, developed "The Nursing Strategy for Canada".

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THE PURPOSE OF THE NURSING STRATEGY

Canada is experiencing a crisis in nursing. This is a view expressed across the country, both in the health system and among the general public. While there are many different perspectives on why this is and what the most promising solutions are, there is significant agreement that the current shortage of nurses is getting worse and that left unchecked, this situation will lead to a deterioration in the quality of the nation's health care system.

In response to these concerns, the Conference of Deputy Ministers/Ministers of Health directed the Advisory Committee on Health Human Resources (ACHHR) to develop a pan-Canadian strategy for nursing. Recognizing the complexity of the issue, they also directed the ACCHR to ensure meaningful consultation with the relevant stakeholders.

The initial document, *Towards a Nursing Strategy for Canada: A Consultation Paper for Stakeholders*, was developed by the Working Group on Nursing Resources and Unregulated Health Care Workers (WGNR), a sub-committee of the Advisory Committee on Health Human Resources, in March, 2000. This initial document offered an analysis of various perceptions held by the different stakeholders in order to establish a common understanding of the complexity of the issue. Twelve strategies for action were proposed. A summary of this work is included as Appendix B.

WGNR members assumed the responsibility to ensure that this document was widely circulated to the relevant stakeholders representing nursing professional associations, labour, educators, and employers in their respective jurisdictions. These stakeholders were asked to consider the proposed strategies and answer two questions:

- Is there support for these proposed strategies?
- Are there alternative or additional suggestions or options that warrant consideration?

Ninety-four formal responses were received by the WGNR. Following consideration of this feedback by the WGNR, this final document, *The Nursing Strategy for Canada*, has been developed for presentation to the Deputy Ministers/Ministers of Health.

THE GOAL OF THE NURSING STRATEGY

The goal of the Nursing Strategy for Canada is to achieve and maintain an adequate supply of nursing personnel who are appropriately educated, distributed and deployed to meet the health needs of Canadian residents.

THE FRAMEWORK FOR THE NURSING STRATEGY

The following framework has provided the foundation for the *Nursing Strategy for Canada*.

The paper is presented from the perspective of governments as stewards of the publicly funded health care system.

This paper is written for presentation to federal/provincial/territorial Deputy Ministers and Ministers of Health for their consideration and proposes action that governments can undertake as stewards of the health care system.

Education and provision of health care are within provincial/territorial jurisdictions, while the federal government plays a leadership role in these areas.

The regulation of the health professions and the planning, funding, management, and delivery of health and education falls within the jurisdiction of the provinces and territories. However, the federal government has an established role in providing leadership, coordination, and research, all essential to addressing this Canada-wide issue.

For the purposes of this document the term "nurse" refers to registered nurses (RNs), registered psychiatric nurses (RPNs), and licensed practical nurses (LPNs).[1]

The full scope of nursing includes work done by LPNs/registered nursing assistants/registered practical nurses, RNs, and RPNs. While each of these three nursing groups has an important role to play, the appropriate mix of their respective knowledge, skills, and abilities must be considered when determining how to best meet the health needs of the population.

The Nursing Strategy for Canada should built upon the principles of the Canada Health Act.

- ✓ Universality
- ✓ Comprehensiveness
- ✓ Portability
- ✓ Public Funding and Administrations
- ✓ Accessibility

[1]Licensed Practical Nurses are also known as Registered Nursing Assistants and Registered Practical Nurses.

Delivery of nursing services should be cost effective.

Health care is a finite resource and the opportunity cost associated with inefficient or ineffective interventions and care is high. Therefore, it is essential that the most cost-effective delivery options for nursing services be identified and promoted by all stakeholders.

Mobility of nurses should not be restricted.

In keeping with the Agreement on Internal Trade, nurses within Canada should not be restricted from practice in any province/territory.

Safe and competent nursing services should be accessible to all Canadian residents.

Nursing services are pivotal to quality health care and, therefore, all Canadian residents should have appropriate access to nursing services.

ISSUES AND PERSPECTIVES

It is important to examine the perspectives on nursing workforce issues held by the many stakeholders in order to establish a common understanding of the complexity of this issue.

Nurses make up approximately two-thirds of all health professionals in Canada, and play a unique role in maintaining a high-quality health care system and meeting the health needs of the population. The public's confidence in Canada's health care system rests largely on maintaining its confidence in health providers; a shortage of nurses and the potential impact of this on the quality of care has a direct affect on that confidence.

The issues associated with the nursing workforce are particularly complex and dynamic and involve multiple stakeholders, including governments, employers, professional associations, unions, and educators. Therefore, addressing these issues requires the full involvement and cooperation of all of these organizations. While each stakeholder supports the goal of a stable and competent supply of nurses, their different roles and responsibilities lead to different perspectives on how to best achieve this.

The strong belief that there is a nursing crisis is shared across Canada, and yet there is less agreement on exactly what this means and various opinions on what to do about it. While there have been a number of reports released that describe and analyze these issues, they have tended to reflect the perspectives of the sponsoring organization rather than a synthesis of many perspectives. While

each perspective is important, the complexity of the nurse workforce requires an integrated solution.

The supply of nurses, their quality and competency, and their retention in jobs and in the profession are all dependent upon many different factors, including educational capacity, clinical training opportunities, entry-to-practice standards, support for new grads, efficient deployment patterns, continuing education opportunities, meaningful careers and supportive work environments. These factors are also largely dependent upon each other. The following summary provides a brief overview of the different issues and includes the perspectives of the many stakeholders as identified during the Invitational Roundtable of Stakeholders in Nursing (November, 1999) and through the consultation process undertaken by the WGNR during the development of this document. These perspectives illustrate the complexity of these issues and the need for improvements in coordination and cooperative action.

Unless otherwise noted, the Nursing Workforce Study[2] is the source for all statistics used in this document. A synopsis of this study, including a brief description of its methodology and the limitations of the data, is provided in Appendix C. It is also important to note that this document relies on aggregate national statistics, and these figures may not reflect the experience within individual jurisdictions. Readers are urged to consult the full Nursing Workforce Study for more detailed information.

HEALTH HUMAN RESOURCE PLANNING IN A CHANGING HEALTH SYSTEM

The Need for Integrated Planning

As stewards of the publicly funded health care system, the federal/provincial/territorial governments share a key role in human resource planning. While this planning is generally undertaken at the provincial/territorial level, consistent with those jurisdictions' responsibility of health and education, the federal government has a role to play in assisting in coordination of Canada-wide policy issues.

At the provincial/territorial level, ensuring future supply of nurses requires close collaboration among the employers, educators, professional regulatory bodies, and labour. While most provincial/territorial departments and ministries responsible for advanced education determine the number of nursing education seats through the annual budget process, they must work closely with the departments and ministries of health to determine optimal need. They also need to work closely with the professional regulatory bodies to approve curriculum and with health system employers to ensure appropriate clinical placements for

[2] Kazanjian, Wood, Rahim-Jamal, and MacDonald, 2000

students. Optimally, all of these stakeholders need to be involved in the process of human resource planning, as each has a key role in determining supply needs and ensuring that these are met.

The Impact of the Changing Health System

While health human resource planning has traditionally been the joint responsibility of the health and advanced education sectors of provincial/territorial governments, the health priorities for these governments during much of the 1990's focused primarily on meeting fiscal targets and achieving health system restructuring and reform. Many provincial health departments and ministries were faced with major restructuring including the potential displacement of thousands of health care workers as hospitals were closed and beds reduced. As a result, their attention was focused primarily on the immediate problems a displaced workforce rather than on planning for future supply and anticipating future shortages.

However, other stakeholders were taking a longer-term view. The Canadian Nurses Association (CNA) released a report in 1997 that predicted a future registered nurse shortage. The following major contributing factors were identified in this report:

- ✓ an aging workforce that will retire in large numbers during the next decade;
- ✓ an aging population predicted to require increased nursing and other health care; and
- ✓ an inadequate number of new graduates.

This study was pivotal in drawing the attention of both governments and employers to the future. It helped refocus the attention of governments to the longer-term perspective needed within health human resource management. The 1990s' health restructuring, reform, and fiscal restraint resulted in a much different health care system that has very different health human resource needs and in response, provincial and territorial governments are beginning to reinvest in human resource planning and development.

Accurately forecasting workforce supply and demand is a complicated exercise. While it must be based upon sound data and quantitative analysis, it must also include many other factors, such as the future design of the health system, health technologies and clinical practice, variations in nurse-mix ratios, deployment patterns, and institutional, long-term and community utilization patterns. The particular mix of any of these types of factors will lead to different results. This points to the fact that there is no right answer or single solution; human resource planning must be done with the full integration of all information, in a transparent

fashion, and focus on developing a number of different but plausible scenarios based on good data and sound policy.

Requirements for Sound Planning

While there is growing recognition that comprehensive human resource planning must be based on sound data, the recent Nursing Workforce Study identified many of the current deficiencies in the available national data. Supply data for registered nurses is limited to registration-related information and there is less national data available for LPNs and RPNs. The inability to accurately and consistently track individuals from application to nursing education, through to graduation, and into the workforce until retirement, limits the reliability and utility of the current data. This means that many of the basic policy questions about nurse supply, deployment, and movement in and out of employment and the profession cannot be answered. Some jurisdictions, such as British Columbia, are exploring the development of a minimum data set; but in the absence of standardized and complete national data, nurses cannot be tracked across jurisdictions and our knowledge of nurse supply will continue to be incomplete. Similarly, little work has been undertaken to predict future supply needs; the same types of caveats that apply to supply projections also apply to this side of the equation.

There is also a need for increased profile for workforce-related nursing research that is relevant to the current policy issues, such as optimal nurse-mix and efficient deployment strategies, and that also reflects the context of the Canadian health care system. Sound nursing management policies and practice need to be based on this type of evidence. Improved mechanisms to systematically disseminate research findings to managers and planners are also required.

The Education of Nurses

Ensuring Nursing is a Career of Choice

Many education programs for RNs experienced reduced applicants for seats during the late 1990s, and in some cases educational institutions replaced those seats with other programs that were more in demand. Registered psychiatric nursing programs experienced large decreases in seats as the closure of large institutions was anticipated. However, more recently, many nursing education programs have reported a renewed interest by prospective students. Despite this renewal of interest, there are concerns that the increases in education capacity required to address future supply requirements will exceed qualified applicants unless nursing comes to be perceived as a more positive career choice.

The availability of alternative career choices, particularly for women who make up nearly 95 percent of registered nurses, and the public perception that nursing

may no longer be as an attractive career option, may mean that educators, professional associations, employers and funders need to find ways to increase the attractiveness of this profession to ensure that there are qualified applicants for new seats.

New Entry to Practice Requirements

The Nursing Competency Project (1997) was initiated in 1994 in response to the rapidly changing health care environment and the recognition by nursing regulatory bodies of the need to plan and prepare nurses for a changing health care system. This project involved Canada-wide consultation with nurses and other stakeholders with the objective of defining optimal entry-level competencies for LPNs, RPNs and RNs.

As a result of this work, revised national examinations for both RNs and LPNs will be implemented in 2000 (RNs) and 2001 (LPNs) based on a new set of competencies being adopted by provincial regulatory bodies. These new competencies reflect changes in the demographics and population health needs, as well as changing health care practice. The new competencies focus less on providing supportive/curative care to individuals in institutional settings and more on the continuum of health care, the use of community practice settings and on an expanded definition of the client that includes groups, communities, and population health. As well, there is more emphasis on the elderly patient, reflecting the changing demographics of health care and of the population. As well, the inclusion of specific competencies on the determinants of health, partnerships, leadership, advocacy, and evidence-based practice reflects the changing culture of practice settings.

Demands for a Changing Health Care System

While the changes to nursing competencies and entry-to-practice would support emerging trends in health care delivery, the pace of actual change within the health system has been slower than anticipated. Approximately 12 percent of RNs reported being employed in the community sector in 1997, an increase from 1990 but smaller than anticipated given the expectations of many health initiatives. Hospitals and nursing homes continue to be the employer for nearly 75 percent of RNs; they are also nearly always the entry-point for graduating nurses.

Within the institutional sector, a number of factors have combined to contribute to significant change in nursing practice. Factors such as increased average acuity resulting from reduced beds and shorter length of stay and the introduction of new technologies and treatments have had significant impact on nursing practice requirements, demanding increased skills, autonomy, and ability to work with multidisciplinary teams.

Over 90 percent of nurses employed in their profession are educated at the diploma level. Even with the introduction of the BSN as the new entry-to-practice requirement in many jurisdictions, it will be many years before these new graduates become representative in the workplace. By far the majority of RNs employed in hospitals and nursing homes have been trained at the diploma level. While experience is an essential attribute of good nursing practice, it must be recognized that this workforce must rely on continuing education and specialty-training opportunities to gain the new knowledge and skills needed to meet the practice requirements evolving from these changes in health care.

Opportunities for continuing education and training are an important quality of care issue but it is also a quality of work life issue: nurses want to have the skill to provide competent care and also meet their own needs for professional satisfaction. Given that the majority of RNs employed in nursing will continue to be diploma-prepared for many years, it is essential to ensure that there are mechanisms and resources to provide them with the competencies they need to do their job now. In addition, it is important to find ways to meet their personal expectations for job satisfaction and safe and quality care to the patient.

Adequate Clinical Placements and Support

For a number of years employers have expressed concerns that new graduates do not have the skills and abilities to enter the direct-care workforce without significant support in the work place. These concerns may reflect a number of different issues. The care needs of patients have changed, while nursing workloads and higher patient acuity may be reducing the flexibility needed to support new grads. The majority of new grads are no longer able to find permanent full-time positions and are often used to fill casual positions that do not offer a stable and supportive environment for academic skills to be transferred to direct patient-care.

Acquiring nursing competencies requires clinical opportunities but many educators have indicated that it is increasingly difficult to ensure students are provided with these opportunities. Employers report that workload and patient acuity make supporting quality clinical placements or providing support for new graduates difficult despite their pivotal role in meeting employers' expectations for a practice-ready workforce. These types of learning and support opportunities are also believed to contribute to retaining nurses within the profession, assisting students to make the challenging transition from the academic to the clinical setting.

A Quality Work Place

Important Factors in the Recruitment and Retention of Nurses

All nursing associations and unions report a deteriorating quality of work life for nurses. Quality of work life is widely believed to be one of the most important factors in recruitment and retention, thus having an impact on the current and the future supply of nurses.

Quality of work life is determined by many factors, many of which are inter-related. The diversity of the nursing workforce and of practice settings means that there is no single work life issue to be addressed, but rather a constellation of issues each contributing in a different way to professional and personal job satisfaction. The range of issues includes appropriate workload, professional leadership and clinical support, adequate continuing education, career mobility and career ladders, flexible scheduling and deployment, professional respect, protection against injuries and diseases related to the work place, and good wages.

As an example, nurses and employers have reported that the reductions of the number of hospital beds resulting from the fiscal restraint of the 1990s led to a reduced average-length-of-stay in many institutions, which in turn, led to higher average patient acuity in both institutions and in the community. This along with increased use of sophisticated technology, more chronically ill patients with concurrent illnesses and an aging population is believed to have increased both the workload of nurses and their competency needs. However, appropriate nurse/patient ratios for these circumstances have not been determined, and as previously discussed, continuing education has not kept pace with need.

Also related to fiscal restraint, head nurses and clinical nurse specialists were eliminated or severely reduced in many jurisdictions. This change reduced professional and clinical support for nurses while also transferring the responsibility for administrative duties, such as scheduling, to front-line nurses. As well, the largest loss of hospital employees during the 1990's restructuring was within the non-nursing staff, such as ward clerks and orderlies; this resulted in many of these non-nursing duties also being reassigned to nurses.

The casualization of the workforce has also been cited as a serious quality of work life issue, as well as requiring more net nurses to meet scheduling demands. This type of deployment is particularly hard on new nurses because it deprives them of a stable work environment with clinical supervision. On the other hand, nurses at different stages in their careers and family lives want different working arrangements, and cite flexibility in scheduling options to meet these needs as a major quality of work life issue.

LPNs and RPNs report a similar perception of deteriorating quality of work life. LPN associations also express concerns that their members are not utilized to their full potential within the hospital setting, and hold the view that determining optimal nurse-mix -- the ratio of RNs to LPNs -- is an important issue to examine when addressing quality of work life.

Managing the Workforce

Nursing Shortages

In the wake of the last decade's focus on health reform, restructuring, and fiscal restraint, employers across the country report that they are unable to recruit to fill new positions made possible by recent increases in government funding to health care. The extent of this shortage cannot be verified as vacancies are no longer routinely reported, but anecdotal reports from employers leave little doubt that this is a serious situation in many jurisdictions. These shortages tend to be different in various jurisdictions. The range of recruitment problems includes casuals, specialty-trained RNs in areas such as critical care, psychiatry and emergency, and nurses with the skills and experience required for remote and independent practice.

In the four western provinces, employers report that recruitment of RPNs has also become increasingly difficult. The long anticipated closure of large institutions reduced the perceived security of this field of nursing and reduced the demand for psychiatric nursing education during the 1990's. As a result, many educational programs reduced their capacity. However, the role of RPNs has expanded to include psychiatric units in acute care hospitals, nursing homes, and expanded community mental health programs, resulting in an increased demand for RPNs.

Employers also report that managing the nursing workforce has become increasingly complex since the fiscal restraint and restructuring of the health care system during the 1990's. The labour accords and collective agreements designed to protect the job security of nurses during the restructuring era reduced the management flexibility of employers. These agreements protected workers by emphasizing the importance of seniority rights and introducing more complicated and specific provisions for terminating or transferring staff. These may have unintentionally contributed to the trend of 'casualization' as employers sought to maintain flexibility within their workforce and as they faced tighter fiscal restraint by governments. More recent collective agreements in some provinces have introduced complicated scheduling and call-in provisions, further reducing the flexibility of employers to manage within the context of a shortage of nurses.

On the other hand, employers continue to maintain a large proportion of their staff as part-time and casual, presumably to maintain staffing flexibility. There is some evidence that this approach to deployment is not the most efficient. A high rate of part-time and casual deployment requires more net nurses, may result in increased overtime for nurses when sufficient staffing can not be found, and adds an administrative burden to staff nurses who have become responsible for scheduling and call-in.

Nursing associations and unions have pointed to the need for full-time positions for new graduates who traditionally rely on employment in direct care positions in hospitals and nursing homes as their entry point to the workforce. These new grads also require stable and well supervised opportunities to assist them in making the transition from education to work place. The availability of permanent positions, either part-time or full-time, has also been identified as an important quality of work life issue for all nurses.

Skill-Mix

Establishing the appropriate balance of RNs and LPNs (as well as other non-regulated nursing groups such as care-aides and orderlies) also poses a problem for employers. While the majority of provinces/territories recognize LPNs, they are not utilized consistently across the country and they report that they frequently work below their trained competency level. The lack of definitive research on the efficacy of various nurse-mix configurations has contributed to ongoing debate about the appropriate utilization of LPNs and may have limited employers from taking the opportunity to maximize LPN skills while augmenting their registered nursing workforce. As previously noted, LPN associations also have concerns that their members are not utilized to their full potential within the work place and have emphasized the need to determine optimal nurse-mix as one means of addressing the current nursing issues.

What We Know

Current Research

The *Nursing Workforce Study* was commissioned by the Advisory Committee on Health Human Resources (ACHHR) and undertaken by the Health Human Resources Unit at the University of British Columbia. This study provides data on the nursing workforce in Canada. RN data is prominent in this report because it is more available than data about LPNs and RPNs. This in itself is an issue to be addressed, as comprehensive workforce planning must include all nursing groups and be data based.

The Nursing Workforce Study presents data that reflects many of the concerns expressed by employers and professional associations and unions. The

production of nurses is not keeping up with population growth and the current cohort of nurses is aging. There has been a significant trend to less full-time employment and an increase in part-time and casual work. The data also reflects the increase of employment in community settings, though this has occurred at a much slower rate than anticipated. The variation in the utilization rate LPNs and RPNs across the country leads to questions as to whether all nurses are used to their full potential. Some of these key findings are discussed in detail in the next section of this report.

STRATEGIES FOR CHANGE

The strategies for change proposed in the Nursing Strategy for Canada are organized according to the following key issues identified in the previous section:

- ✓ unified action;
- ✓ improved data, research and human resource planning;
- ✓ appropriate education, and
- ✓ improved deployment and retention strategies.

These strategies are proposed with the understanding that further development and implementation of each strategy will require the unifying efforts of all stakeholders. Lead responsibility and the suggested timeline for each strategy are identified.

The cost implications of these strategies will have to be considered by federal/provincial/territorial governments and stakeholders to identify potential funding sources and reflect fiscal capacities. Estimated costs for one-time strategies that are the responsibility of the federal government are provided.

I. UNIFIED ACTION

The brief summary of issues and perspectives presented in the previous section illustrates the complexity of the nursing situation. There are multiple issues and multiple stakeholders sometimes with different perspectives on the same issue. Without recognized coordinated and joint action these issues cannot be successfully addressed.

STRATEGY 1

The federal government and provincial/territorial governments immediately establish a multi-stakeholder Canadian Nursing Advisory Committee (CNAC) to address priority issues as identified by the Advisory Committee on Health Human Resources (ACHHR) and the Working Group on Nursing Resources and Unregulated Health Care Workers (WGNR). The key focus for CNAC for 2000/01 will be improving the quality of work life for nurses and providing advice to support the implementation of other strategies of the Nursing Strategy for Canada.

Key points:

The initial focus for CNAC will be to develop a set of Canada-wide and evidence based policy directions for improving the quality of work life for nurses that reflect an integrated stakeholder perspective. This policy framework will provide a context for related work at the provincial/territorial level.

CNAC will act as a reference group to provide advice and support from an integrated stakeholder perspective for the implementation of other strategies within this document (e.g. improvements to the nursing database).

CNAC will work closely with other relevant committees and bodies (e.g. the Sector Study, the Primary Care Working Group, the Advisory Committee on Health Services and the Advisory Committee on Health Information to ensure coordinated efforts).

CNAC will report to ACCHR and will provide ACCHR with a report on their progress within one year; ACCHR will table this report with the Conference of Deputy Ministers at the first available opportunity.

CNAC will be established with a twelve-month mandate; ongoing requirements and future role and mandate will be reviewed at the end of this period.

CNAC will require resources to support travel, secretariat, and research activities.

Appointments to this Council will be made by the ACCHR following a nomination process. Federal, provincial and territorial governments will be invited to nominate a fixed number of 'experts' representing the key stakeholder groups, including governments, the three nursing groups (i.e. RNs, LPNs and RPNs), nurse educators, labour, and employers. Representatives will be selected to reflect institutional, continuing care and community practice settings.

Membership of CNAC will be limited to 15 representatives.

Lead Responsibility: ACHHR
Timing: Immediate

STRATEGY 2

A Nursing Advisory Committee (NAC) be established (where an equivalent body does not exist) by each province and territory to support the development of strategies for improved nurse human resource planning and management within each jurisdiction.

Key Points

It is recognized that some jurisdictions have equivalent or similar bodies/ processes in place, which may be used for this purpose.

Lead Responsibility: Provincial/Territorial ACHHR representatives
Timing: Immediate

II. IMPROVED DATA, RESEARCH AND HUMAN RESOURCE PLANNING

As noted previously, the lack of national data makes seemingly simple questions about current nursing supply difficult to answer. The *Nursing Workforce Study* examined the available data on the supply of nursing personnel in the provinces and territories in order to provide basic information about education (age, type and place) and employment status (deployment, areas of responsibility, type of position, work hours). This study was based on data collected by regulatory bodies in their registration and renewal process. Table One illustrates many of the changes that have occurred within the registered nurse workforce between 1990 and 1997.

Registration data for RNs was received from Statistics Canada and the Canadian Institute for Health Information but information about RPNs and LPNs was obtained directly from their provincial regulatory bodies. It is important to note that since there is no national collection system for LPN and RPN data, there is no standardized format for data collection and reporting and so not all data requested was available for these two groups. While this gives the appearance that RN issues predominate the analysis, this is due to the lack of data for the other nursing groups

Within the limitations of the data available, the *Nursing Workforce Study* provides an extensive review of the changes in the nursing workforce during the past decade. These statistics substantiate many of the concerns that have been raised throughout the health care system. In 1997, there were fewer RNs employed in nursing per 10,000 population and fewer RNs employed as a percentage of all RNs than seven years earlier.

The aging of the nursing workforce is readily apparent, illustrated by the decline in the number of nurses under 35 years and the increase in the number of nurses over 45.

Casual employment increased to over 18 percent of employed RNs during this time period, with nearly 1 in 5 employed RNs working on this basis. While employment in the community nearly doubled during this time period, it still accounted for only 12.83 percent of all employed RNs in 1997, whereas employment in hospitals and nursing homes/long-term care facilities accounted for over 73 percent of RNs.

Clinical administration, such as head nurses and clinical specialists, declined. RNs working in education also declined, as did those in direct patient care. The number of RNs with baccalaureate degrees increased just over 2 percent. Just over 90 percent of RNs employed in nursing were educated at the diploma level.

TABLE ONE

Registered Nurses Employed in Nursing by Selected Factors, 1990 and 1997

Part A (includes Quebec) [1]	1990		1997		Percent Change in Number [1]	Annualized Percent Change in Ratio [1]
	Number [1]	(Percent) [1]	Number [1]	(Percent) [1]		
Population of Canada [2]	27700856	--	29987214	--	8.25	--
RNs employed in nursing (% of total RNs) [3,4]	223964	(87.44)	240173	(86.63)	7.24	-0.13
Number of RNs employed in nursing per 10,000 population	80.85	--	80.09	--	--	-0.13
RNs employed in nursing in Prov/Terr (% of total RNs) [3,4]	223964	(87.44)	229838	(82.90)	2.62	-0.76
RNs with basic diploma education (% of RNs employed in nursing in Prov/Terr) [3]	207081	(92.46)	206964	(90.05)	-0.06	-0.38
RNs with basic baccalaureate education (% of RNs employed in nursing in Prov/Terr) [3]	16820	(7.51)	22795	(9.92)	35.52	4.05
RNs whose place of graduation was outside Canada (% of RNs employed in nursing in Prov/Terr) [3]	19144	(8.55)	17767	(7.73)	-7.19	-1.43
All RNs employed in nursing aged < 35 years (% of RNs employed in nursing in Prov/Terr) [3]	74134	(33.10)	54842	(23.86)	-26.02	-4.57
All RNs employed in nursing aged > 45 years (% of RNs employed in nursing in Prov/Terr) [3]	69240	(30.92)	97625	(42.48)	41.00	4.64

[1] **These data include Quebec as data were available for Quebec in both 1990 and 1997.**

[2] Source: Statistics Canada, Population by Age by Sex Canada, CANSIM series C892268, January 25, 2000.

[3] Source: Project B Tables 1, 2, 3, 4, 12, and 13, *Nursing Workforce Study*, Kazanjian et al.

[4] Detailed information on the number of RNs employed out of Prov/Terr were available in 1997, but not in 1990, thus the 1997 data

For 'RNs employed in nursing' and 'RNs employed in nursing in Prov/Terr' differ while the 1990 data are the same.

Part B (excludes Quebec) [1,2]	1990		1997		Percent Change in Number (excluding Quebec) [1,2]	Annualized Percent Change in Ratio (excluding Quebec) [1,2]	1997 Total Number (including Quebec)
	Number (excluding Quebec) [1]	(Percent excluding Quebec) [1]	Number (excluding Quebec) [2]	(Percent excluding Quebec) [2]			
RNs employed in nursing where residence and employment status is known (% of total RNs) [3]	166463	(84.39)	170608	(81.14)	2.49	-0.56	229838
RNs working in regular full-time positions (% of RNs employed in nursing where residence and employment status is known) [3]	93234	(56.01)	85315	(50.01)	-8.49	-1.61	114338
RNs working in regular part-time positions (% of RNs employed in nursing where residence and employment status is known) [3]	48146	(28.92)	52832	(30.97)	9.73	0.98	73168
RNs working casual (% of RNs employed in nursing where residence and employment status is known) [3]	23419	(14.07)	32197	(18.87)	37.48	4.29	42068
RNs working in hospitals (% of RNs employed in nursing where residence and employment status is known) [3]	120087	(72.14)	105211	(61.67)	-12.39	-2.22	140676
RNs working in nursing home/ltc (% of RNs employed in nursing where residence and employment status is known) [3]	11777	(7.07)	18504	(10.85)	57.12	6.29	27865
RNs working in community settings (% of RNs employed in nursing where residence and employment status is known) [3]	15050	(9.04)	20714	(12.14)	37.63	4.30	29479
RNs working in direct patient care (% of RNs employed in nursing where residence and employment status is known) [3]	143094	(85.96)	148004	(86.75)	3.43	0.13	189897
RNs working in administration (% of RNs employed in nursing where residence and employment status is known) [3]	10811	(6.49)	7327	(4.29)	-32.23	-5.74	14964

[1] Quebec is excluded from the 1990 data as detailed data on employment were not available for Quebec in 1990.
[2] Quebec is excluded from the 1997 data so that comparisons can be made to the 1990 data.
[3] Source: Project B Tables 1, 2, 5, 6, 7, and 8, *Nursing Workforce Study*, Kazanjian et al.

While these data provide support for many of the concerns expressed by stakeholders, the authors of The Workforce Study stress that the data currently available is not adequate to answer many of the fundamental questions about supply. The authors further suggest this limitation could be best addressed from a national perspective by introducing a national unique identifier for nurses. This would allow the tracking of nurses through their education and work life, allowing researchers, policy makers and planners to examine in detail important factors such as attrition, retention, inter-provincial mobility and movement in or out of the country. This would allow policy makers to draw much more meaningful conclusions from the data. National databases are also needed for LPNs and RPNs, with recognized and agreed upon standards for data collection, management and transmission, in order that all nursing groups can be better represented in future workforce analysis and planning.

Given the limitations of the current data and the related limitations of nursing policy, it is difficult to develop precise future supply projections or requirements. Nevertheless, Kazanjian et al. offered one possible scenario of future requirements based on the data available. The authors examined how rapidly the RN workforce could be replaced, as existing nurses retire or otherwise leave the profession. Using the 1997 RN workforce, the study was based on the following assumptions:

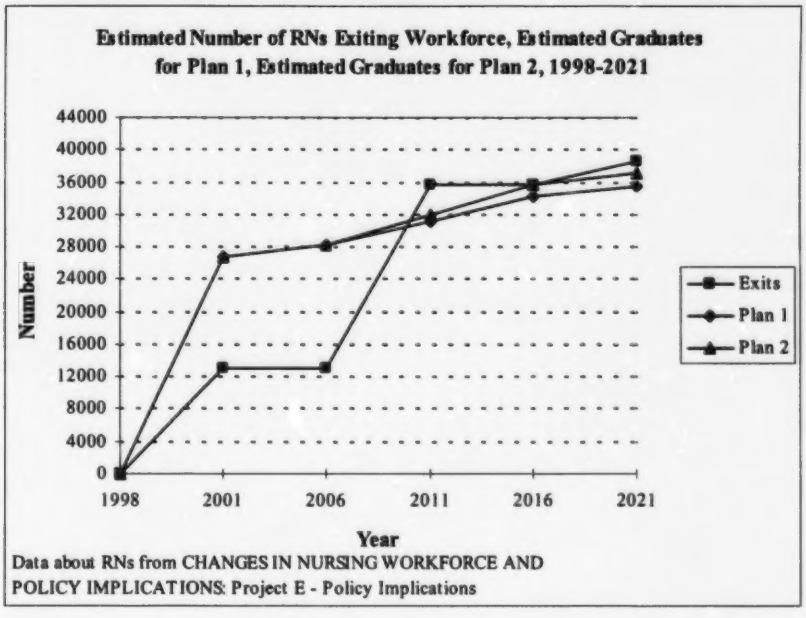
- ✓ regular rates of exit/retirement between 1997 and 2021;
- ✓ no intake from reactivation;
- ✓ no attrition, and
- ✓ the same number of graduates was estimated for 2002 until 2021.

Their model determined that incorporating a 10 percent increase in graduates in 2000, 2005 and 2210, and assuming a 4-year lag for educational preparation, would result in an increase of approximately 2.5 percent, or 6,033 RNs (Plan 1). Using a 10 percent increase for 2000 and 2010 and a 15 percent increase for 2005, would result in an increase of 6,914 nurses over 1997, a 2.7 percent increase (Plan 2). While this model does not try to predict future demand, it provides policy makers and planners with an estimate of the impact on supply of a relatively modest increase in education capacity over 24 years.

The impact of such a modest increase can be assessed by using a simple comparison of the average rate of change in the estimated numbers of RNs resulting from no additional graduates, the change resulting from Plan 1 (i.e. a 10 percent increase in graduates in 2000, 2005 and 2010), and the predicted change in general population. The rate of population growth, though predicted to decline after 2006, can be seen to continue to exceed the predicted growth of RNs under both scenarios. Also of interest is the rate of change for women aged 20-64, given the nursing workforce is 96 percent female: the projected decline in this population exceeds that projected for the general population. These

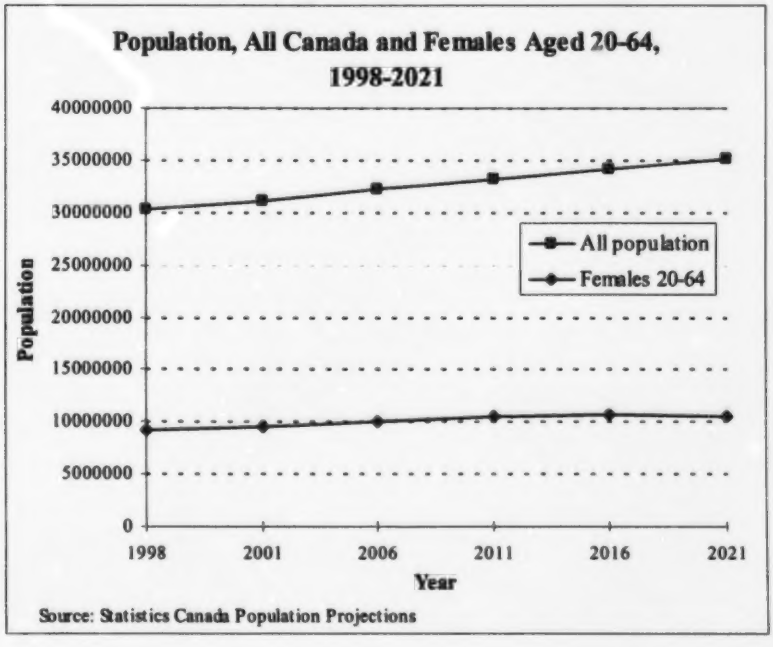
comparisons are illustrated in Chart One and Two below. Further work considering the impact of different policies, such as nurse deployment, nurse-mix and service utilization patterns, is required in order to refine these projections and link them to future demand requirements.

CHART ONE



Data about RNs from CHANGES IN NURSING WORKFORCE AND POLICY IMPLICATIONS: Project E - Policy Implications

CHART TWO



Source: Statistics Canada Population Projections

The Canadian Nurses Association has also monitored the supply of nurses for a number of years and commissioned several reports on the supply, recruitment, and retention of RNs. *A Statistical Picture of the Past, Present and Future of Registered Nurses in Canada* (1997), prepared by Eva Ryten, has been the most frequently cited study on the future of the nursing supply and demand in Canada. This report predicted that if the demand for nursing rises only to accommodate projected population growth (i.e. 23 percent between 1993 and 2011), there will be a shortage of 59,000 nurses by 2011. If demand increases both to accommodate population growth and extra need generated from the aging of the population (i.e. 46 percent between 1993 and 2011), there will be a shortage of 113,000 nurses.

This study calculated the future demand for nurses by using rates of utilization of hospital days by age and sex. Future supply of nurses was calculated by projecting the retention of all nurses registered in 1995 into 2011, and by projecting addition to the RN pool each year from 1995 to 2010 inclusive. Adding these two projections together yields an estimate of the supply of RNs in 2011 and of the age distribution of that supply. The results show for 2011 a complement of 266,000 RNs of whom 231,000 will be employed in nursing and within that cohort there will be as many 60 year olds as 30 year olds.

The conclusions of the Ryten study regarding future demand were based upon acute care utilization by age and sex for 1994. Demand forecasting of this type is based upon the assumption that utilization patterns are constant and there will be no adjustment for changing patterns of illness and treatment. The study also assumed no change in the deployment of LPNs or RPNs and assumed the entire RN workforce would require replacement in order to maintain current levels of staffing in acute care facilities.

The differences in these two studies illustrate the difficulty in predicting supply and demand in this workforce -- very reasonable but different assumptions will result in different projections. As Kazanjian et al. have reported, the absence of comprehensive and reliable data for all types of nurses reduces the ability of researchers to make accurate predictions. Similarly, the policy assumptions on which such work is based have significant affect upon a study's conclusions. Determining policy on issues such as the use of different types of nurses (nurse-mix), funding levels, utilization patterns, deployment patterns, etc. is essential to future workforce planning. The development of projection models that are well established and evidence-based is dependent upon the integration of comprehensive and quality data and sound policy development.

STRATEGY 3

The federal/provincial/territorial governments encourage the efforts of the Canadian Institute for Health Information (CIHI) and other organizations to develop the information required for the effective planning and evaluation of nursing resources.

Key Points:

Data on all nursing groups is required.

Activities will include the identification of information needs, development of new data standards and databases, and implementation in the provinces and territories by data suppliers (e.g. relevant licensing authorities, employers and educational facilities).

Consideration should be given to the development and implementation of a unique identifier for all nurses.

Lead Responsibility: ACHHR / CNAC / CIHI
Timelines: 2000 - 2003

STRATEGY 4

The ACHHR work with major research funders to identify gaps in current research, to profile workforce planning issues for new research funding, and recommend improved mechanisms for the dissemination of these research results to policy makers and managers.

Key points:

Increased nursing research is needed to support the development of evidence-based nursing policy and workforce planning.

Efforts are needed to improve the interface between nursing research and policy makers.

Lead Responsibility: ACHHR
Timelines: During 2000/2001

STRATEGY 5

The federal government provide leadership to ensure the development of improved projections for nursing supply/demand requirements to the year 2015.

Key Points:

There is a need to expand health human resource planning beyond simple supply models.

Recognizing the provincial/territorial responsibilities for health human resource planning and the different needs in each jurisdiction, emphasis should be on determining scenarios, which can be tailored to the needs of an individual jurisdiction.

Terms of reference for the Nursing Sector Study are underway under the auspices of the Human Resources Development Canada.

Lead Responsibility:	Federal government
Timelines:	Establish improved projections within 24 months

III. APPROPRIATE EDUCATION

The majority of nurses employed in Canada graduate from a Canadian nursing program. For example, in 1997, just fewer than 8 percent of RNs employed in nursing reported their place of graduation as outside of Canada, a reduction from 1990. While Canada will remain an attractive destination for skilled immigrants, nursing programs in Canada are likely to continue to be the most important determinant of the supply of nurses in the foreseeable future. The necessity of nursing education is important from not only the supply perspective but also from the perspective of quality practice. The knowledge, skills and abilities of nursing graduates must meet the needs of the health care system.

Career choices are influenced by the availability of permanent employment, good wages and working conditions, and career mobility and flexibility. By the mid-1990s, nursing had become a less attractive career option largely due to the actual or anticipated restructuring of the health system and the reduction in full-time positions. As well, many women increasingly have more career options available to them through post-secondary education. Men continue to be vastly under-represented in both nursing education programs and in graduates/registrants; only 4 percent of registered nurses are male.

Many colleges and universities reduced their nursing seats during the 1990s in response to declining applicants during those years. For example, Ryten (1997) provided data on trends in applicants to B.Sc. Programs in Ontario. She reported that between 1976 and 1997 the selection of nursing as first choice of career dropped from 81.1 percent to 69 percent.
Traditionally, the demand for nursing school placements has reflected changes in the demand for nurses; as demand increased, it was expected that applicants would also increase. However, nursing now competes with many other professions for qualified applicants. Unless nursing as a career is perceived to compare favorably with other options for young people of both genders, it may not be possible to fill these seats with qualified students who are committed to careers in nursing.

STRATEGY 6

A communications strategy be developed with the goal of increasing the public's awareness of nursing as a positive career choice and increasing the number of qualified applicants to nursing schools.

Key Points

A generic strategy will be developed that can be implemented as required by individual provinces/territories.

It is recommended that the strategy be coordinated with appropriate education capacity and the availability of full-time jobs for graduates.

This strategy should be directed to both men and women and all diversity groups.

Lead Responsibility:	ACCHR / Nursing Organizations
Timelines:	Immediate

Nursing Program Capacity

Projecting future supply and, therefore, determining the appropriate number of new nursing graduates required annually is a complicated process. While more work is required to enable more accurate future predictions, the work of both Ryten and Kazanjian et al. illustrates that without increases in nursing school placements, the number of nurses will continue to drop. Given the current shortages and the anticipation the next decade will see a higher rate of retirement from the profession, it would seem prudent for provincial governments to begin immediately increasing the number of nursing program seats.

It is also important to note that some educators have informally estimated attrition of registered nursing students prior to graduation to be as high as 25 percent across Canada. There is no definitive data to substantiate this but this report warrants further exploration by educators. It is essential that these seats are filled by qualified students who are also provided with the clinical experiences and support needed to retain their commitment and ensure the good use of this educational investment.

STRATEGY 7

The number of nursing education seats be increased Canada-wide by at least 10 percent over 1998/99 levels over the next 2 years (2000/2002), and increases in following years be based upon improved demand projections and provincial/territorial need and capability.

Key points:

While many stakeholders will view 10 percent as too conservative, it is a realistic and feasible increase given current provincial initiatives.

More definitive supply requirements will be identified as part of the planned Sector Study referred to in Strategy 5.

It is essential these increases to nursing program seats are accompanied by increases in opportunities for full-time employment for graduating students and appropriate support within the work place to ensure their integration within the profession, as outlined in Strategy 9.

Lead Responsibility:	Provincial/Territorial governments
Timelines:	2000 - 2002

Maximizing the Utilization and Capacity of All Nurses

As previously noted, the nursing workforce is made up of three categories of nurses -- RNs, LPNs and RPNs. There have been few systematic attempts to determine how to most efficiently and appropriately deploy these different categories of nurses and how their variety of skills and capacities could best be matched to the needs of the population and the health care system.

LPN associations and some employers believe that the use of LPNs as part of the nursing workforce has not been fully optimized, despite the need for registered nurses to take on the challenges of increasingly independent and technological work. As well, all nursing groups identify the reduction on non-nursing staff, such as orderlies, porters and ward clerks, as contributing to inefficient use of nursing personnel.

There is also considerable diversity within the registered nursing category itself. One can assume that the competencies of diploma nurses who graduated in previous decades are quite different from those of the newer graduates, and the competencies of BSN grads will be different yet again. The common view has been "a nurse is a nurse"; but this diversity of training and education suggests this may not be entirely true. There may be opportunities to use RNs with different types of competencies in specific roles that will optomize their value while also providing those nurses with maximum job satisfaction. While the professional regulatory bodies are working towards ensuring all RNs possess the new competencies, the reality is this will take many years and will require a significant investment in continuing education.

Specialty training programs have existed for a number of years and many nurses have elected to take these programs to prepare themselves for roles in specialty settings, such as critical care, gerontology and rehabilitation. Developments in medical practice and technology contribute to the importance of specialty training for nurses. As well, provincial governments have begun to commit additional funding to reducing surgical wait lists, and providing more responsive care to acute cases and this is increasing the demand for RNs with special skills in these areas.

However, this type of training and education has not generally been developed as an integral part of nursing education. In some jurisdictions it is not formally linked to the baccalaureate degree or other formal certification, and may be provided by hospitals themselves. Nurses report that these programs are often not formally recognized, do not provide a ladder to other formally recognized qualifications, and may not always be portable within or across jurisdictions.

Despite a changing health system that promises to require more specialization, there is currently little incentive for nurses to chose to take this training given the difficulties in blending concurrent work and education, lack of financial support from employers, and the absence of a formal link to universally recognized qualifications. As well, this additional training is usually not recognized by additional compensation despite the increased expertise and responsibilities associated with specialty nursing roles.

Despite the essential nature of these specialized skills, there is currently no mechanism to track the number of RNs receiving speciality education or working in positions requiring this type of training. Kazanjian et al. reports that RNs reporting non-basic non-degree education fell substantially between 1990 and 1997. While it is not clear from this data that this refers solely to speciality training, it does suggest that while changes in the health system reflect the need for increasing numbers of speciality trained RNs, this type of preparation may actually be in decline.

The lack of a strategy for nursing that begins with identifying the needs of the population and the health care system as a whole, and in turn looks at the nursing profession as a whole, has resulted in a piecemeal understanding of the nursing workforce problem. It is essential that a more holistic examination of the entire nursing profession be undertaken. This comprehensive approach will involve looking beyond the scopes of any one nursing group to consider patient and population needs and determining how nurses together can use their skills and capacities to better meet those needs.

STRATEGY 8

Each provincial/territorial NAC or equivalent body develop a comprehensive strategy to determine what types of nursing human resources are required and for which practice settings, based on an analysis of the needs of the population, of the health system as a whole, and the skills and capacities of all types of nurses.

Major Points:

This review will identify the current respective roles and responsibilities, competencies, education, and utilization patterns of all nursing groups.

Lead Responsibility:	Provincial / Territorial NACs
Timelines:	Immediate with completion in the Spring 2001

STRATEGY 9

Each provincial/territorial NACs or equivalent body develop a five-year provincial/territorial Nursing Education Plan based on the comprehensive strategy proposed in Strategy 8.

Major points:

Plans should include an assessment of current nursing education (basic, continuing, speciality, and advanced) for all nursing groups.

The registered nursing component should include all levels of training, including entry-level, speciality training and post-graduate (e.g., Masters/Ph.D. nurse educators).

The plan should provide recommendations to rationalize, modify, augment, or organize these programs to best meet the supply needs of the jurisdiction during the next 5 years.

Appropriate clinical education for students needs to be addressed as part of this plan.

Ensuring strategies to provide appropriate support/mentoring and orientation for new graduates will help to ensure their positive integration and retention within the workforce.

This strategy will require the active participation of professional regulatory bodies, educators, employers and funders.

Lead Responsibility: Provincial/Territorial NACs or equivalent body
Timelines: 2000 - 2002

IV. IMPROVED DEPLOYMENT AND RETENTION STRATEGIES.

While education is the most important factor in producing nurses, how they are utilized or managed as a resource has a direct affect on supply requirements and on retention in both jobs and the profession. Studies on the workforce tend to focus on increasing the pool of nurses and ignore the active pool of employed nurses that could be managed more efficiently or retained longer in the workforce.

Research has demonstrated that deployment patterns, (full-time, part-time and casual) will affect supply by requiring different numbers of nurses to fill a set number of positions (Kazanjian, 1991). Nurses' satisfaction with these scheduling patterns will also affect how much they are willing or able to work and, in the case of new graduates, may largely affect the quality of their work and also determine their attachment to the profession.

The quality of the workplace also has a significant affect, largely determining job and professional satisfaction, which in turn has an impact upon both job retention and retention within the profession.

Deployment of the Nursing Workforce

Kazanjian et al. indicate that between 1990 and 1997, nurses reporting employment in regular full-time positions dropped from 56.01 percent to 50.01 percent, while those in regular part-time employment rose from 28.92 percent to

30.97 percent, and those in casual employment rose from 14.07 percent to 18.87 percent. The results of earlier research suggest that this increase in part-time and casual employment may be placing increased supply requirements on the workforce through inefficient use of existing personnel. In an earlier study, Kazanjian (1991) demonstrated the impact of different deployment models on nurse requirements and recommended that hospitals facing nursing shortages improve their utilization of nurses though improved management practices. The reduction in full-time nursing positions has been of particular disadvantage for new graduates who traditionally enter direct care positions in hospitals and nursing homes with the expectation of a period of supervision and mentoring to assist them to integrate into the workplace. There is concern that the decrease of full-time positions has affected primarily this group of nurses, who when unable to find full-time jobs, may leave the profession. The lack of supportive employment opportunities in those first few years has also been speculated to have long-term impact on those nurses' skills and abilities. Nurses graduating in the next decade must have the opportunity to work full-time.

While part-time and casual staffing patterns may provide more flexibility for the employer, they place an increased administrative burden on nurse managers whose numbers have been reduced. In some cases, these responsibilities have been transferred to staff nurses and compete with clinical responsibilities. Nurses report that it is more difficult to ensure appropriate clinical staffing when using a casual pool rather than having dedicated staffing. Difficulties in securing staff through complicated call-in provisions may be leading to additional overtime and overwork for regular staff when casual relief cannot be found, further reducing the quality of work life for nurses.

Without a significant increase in the proportion of full-time positions, these trends will continue. This will require hospitals and other employers to review their policies and convert current part-time and casual positions to full-time, and for employers, unions and professional associations to re-examine relevant policies and provisions within collective agreements to ensure they do not create unintended barriers to full-time employment.

Retention Issues in Nursing

Nurses have traditionally looked at their profession as a long-term career in which there is an expectation of career advancement, development, increased autonomy, respect, and job satisfaction. While research has indicated that the vast majority of nurses have traditionally stayed with their profession, recent informal reports from employers and professional associations suggest that this historical trend may be changing. There is growing concern as the profession ages, that many nurses may choose to leave the profession prematurely, reducing the active workforce. The aging of the current cohort of nurses has led to interest in flexible, family-friendly scheduling, less tolerance and endurance of

excessive workloads, and the physical and emotional challenges associated with many direct care positions. In recent years, nursing associations have lobbied for the option of early retirement to be extended to nurses, similar to other high-stress occupations.

The premature exit of a large number of nurses from the active workforce and from the profession would have a serious impact on the current fragile supply of nurses. Efforts must be taken to fully understand the factors which may lead to premature retirement and strategies developed and implemented to address these in order to retain nurses within the workforce for as long as possible.

The importance of a quality work place in maintaining job and professional satisfaction, and therefore improving retention, has been substantiated in the research literature. For example, "magnet hospitals" have been described as hospitals whose management and professional practices are successful in maintaining low staff turnover, adequate staffing levels, flexible scheduling, strong nurse leadership, participative management, professional and career opportunities and so on. These hospitals are reported to have greater satisfaction in their nursing staff and able to maintain staffing levels more easily than hospitals, which do not possess such characteristics. The value of these examples should not be overlooked and strategies proven successful in other jurisdictions should be considered for adoption.

The education of nurses is a significant investment for government, for society, and for individuals. Immediate efforts must be made to improve the quality of work life of nurses in order that it does not contribute to premature withdrawal from the job, the workforce, and the profession.

STRATEGY 10

Provincial/territorial NACs (or equivalent body) identify and support the implementation of retention strategies for their respective workforces that focus on improving the quality of the work lives of nurses.

Major Points:

Strategies should be evidence-based wherever possible.

Key strategies could include:

- ✓ *addressing appropriate nurse/patient ratios;*
- ✓ *utilizing an efficient and appropriate nurse mix;*
- ✓ *reduction of non-nursing duties;*
- ✓ *preventing workplace injuries and illness;*
- ✓ *reducing casualization and increasing permanent positions;*

- ✓ *implementing improved flexibility/family-friendly scheduling options and customized work arrangements;*
- ✓ *reintroducing/enhancing clinical leadership at the bed/ward/unit level; and*
- ✓ *ensuring appropriate opportunities for continuing education and practice development (linked with Strategy 9.)*

Lead Responsibility: Provincial/Territorial NACs or equivalent body
Timelines: 2000 - 2002

STRATEGY 11

Provincial/territorial NACs (or equivalent body) examine opportunities to encourage nurses to re-enter the workforce.

Key Points

The selection of specific strategies must remain the discretion of individual provinces/territories.

Lead Responsibility: Provincial/Territorial NACs or equivalent body
Timelines: 2000 - 2002

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APPENDIX A
RESPONSES TO CONSULTATION DOCUMENT

PROVINCE / TERRITORY	GROUP	ORGANIZATION	RESPONDEE & ADDRESS	DATE RECEIVED	NOTES
British Columbia	Labour	HEU	Chris Allnut, Secretary-Business Manager	28-Apr-00	Received via fax
		BCNU	Cathy Ferguson, President	25-Apr-00	Received via e-mail - NRRC executive summary and recommendations attached
	Professional / Regulatory	College of LPNs of BC	Carolyn Sams, Executive Director / Registrar	1-May-00	Received via e-mail
		RNABC	Sandra Regan, Nursing Policy Consultant, 2855 Arbutus St. Vancouver BC, V6Y 3Y8	14-Apr-00	Received via fax
	Educators	Collaborative Nursing Program in BC	Janet L. Storch, Chair, Collaborative Nursing Program in BC	14-Apr-00	Received via fax
		Health Sciences Deans and Directors Committee	Joy Holmwood, Chair of Health Sciences Deans and Directors Committee and Dean, Faculty of Health Sciences Douglas College	17-Apr-00	Received via fax
		University of Victoria, School of Nursing	Lynne Young	April 20,2000	Received via e-mail, fax and mail
		University of Victoria, School of Nursing	Particia Rodney & Colleen Varcoe, Assistant Professors	17-Apr-00	Received via e-mail
		Nursing Education Council of BC	Janet L. Storch, Chair	14-Apr-00	Received via fax
	Employers	C&W Health Center	Heather Mass, Chief of Nursing, 4500 Oak St, RM B244, Vancouver, V6H 3N1, hmass@cw.bc.ca	25-May-00	Received via mail
		HEABC	Gary Moser, CEO #200-1333 West Broadway, Vancouver BC, V6H 4C6	17-Apr-00	Received via fax
	Other				
Alberta	Labour				
	Professional / Regulatory	College of Licensed Practice Nurses of Alberta	Pat Fredrickson, patf.clpna@compusmart.ab.ca	11-Apr-00	Received via e-mail
		Registered Psychiatric Nurses Association of Alberta	201, 9711-45th Ave, Edmonton AB, T6E 5V8	14-Apr-00	Received via fax
		Alberta Association of Registered Nursing	Louise Rogers, President, rlapoint@nurses.ab.ca	14-Apr-00	Received via e-mail
	Educators	Grant MacEwan College	Barbara Wilson, Health and Community Studies Nursing, P.O. Box 1796 Edmonton AB T5J 2P2	11-Apr-00	Received via mail

	Employers	Calgary Regional Health Authority	Maureen Best, Administrative Leader Nursing Corporate Support, Arlene Weidner, Senior Operating Officer, lena.leyton@CHRA-Health.ab.ca	14-Apr-00	Received via e-mail
		Cross Cancer Institute, Northern Alberta Cancer Program	Greta Cummings, Director of Nursing, 11560 University Ave Edmonton AB, T6G1Z2	14-Apr-00	Received via fax
	Other				
Saskatchewan	Labour	Saskatchewan Union of Nurses	Rosalee Longmoore, President	25-Apr-00	Received via mail
	Professional / Regulatory	Registered Psychiatric Nurses Association of Saskatchewan	Joy Johnson, Executive Director, rpnas@rpnas.com	11-Apr-00	Received via e-mail
		Saskatchewan Registered Nurses Association	Rivie Seaberg, Executive Director dbrunsk@srna.org	14-Apr-00	Received via e-mail
	Educators	Saskatchewan Indian Federated College: Science Department	Prof. Sherri Tutt, Health and Nursing Programs	18-Apr-00	Received via e-mail
		University of Saskatchewan	Yvvone Brown, Dean, College of Nursing, Health Sciences Building, University of Saskatchewan 107 Wiggins Rd, Saskatoon, SK S7N 5E5	14-Apr-00	Received via fax
	Employers	Saskatoon District health	Brian Morgan, Acting President and CEO	20-Apr-00	Received via mail
		Northwest Health District, Meadow Lake Hospital	D. Corey, 711 Centre St. Meadow Lake, SK S9X 1E6	11-Apr-00	Received via fax
		???	Valerie Mashenski, CEO - valerie.mashinski.crc@main.nlnet.melfort.sk.ca	25-Apr-00	Received via e-mail
		Saskatchewan Association of Health Organizations	R.M. Louise Simard, Q.C. President & CEO	2-May-00	Received via mail
		Lloydminster Health District	Gayle Almond, Health Services Director, 3820-43 Ave, Lloydminser, SK/AB S9V 1Y5	14-Apr-00	Received via fax
	Other	College of Physicians & Surgeons of Saskatchewan	D.A. Kendel, M.D., Registrar, G.W. Peacock Building 211-4th Ave. South, Saskatoon, SK S7K 1N1	28-Mar-00	Received via mail
Manitoba	Labour				
	Professional / Regulatory	Manitoba Association of Registered Nurses	Susan Neilson, Executive Director	25-Apr-00	Received via fax
		Registered Psychiatric Nurses Association of Manitoba	Annette Osted, Executive Director, 1854 Portage Ave, Winnipeg, MB R3J 0G9	14-Apr-00	Received via fax
		Manitoba Association of Licensed Practical Nurses	Helen Rempel, President, 200-1601 Regent Ave, Winnipeg, MB R2C 3B3	14-Apr-00	Received via fax

	Educators	Council on Post-Secondary Education	Leo LeTourneau, Executive Director, 410 Portage Ave., Winnipeg MB R3C 0C4	April 17, 2000	Received via mail
		Keewatin Community College, Office of the President	Anthony E. Bos	20-Apr-00	Received via fax
		University of Manitoba, Faculty of Nursing	Dr. David Gregory, Dean	9-May-00	Received via fax
		Assiniboine Community College	Diane Shamray, Chairperson, Health and Human Services, 1430 Victoria Ave East, Brandon MB R7A 2A9	17-Apr-00	Received via fax
	Employers	Winnipeg Regional Health Authority	Jan Currie, Vice President and Chief Nursing Officer	5-May-00	Received via mail
		Parkland Regional Health Authority	Yvonne Hrynkiw, VP Community	1-May-00	Received via mail
	Other	Provincial Nursing Resources Task Force	Mrs. Carmel Olson, Chair, Carmel@westman.wave.ca	17-Apr-00	Received via e-mail
Ontario	Labour	Ontario Nurses Association	Barb Wahl, ONA President, 85 Grenville St, Suite 400 Toronto, ON M5S 3A2	11-Apr-00	Received via fax
		Ontario Public Service Employees Union	Leah Casselman, President, 100 Lesmill Rd, Toronto, ON M3B 3P8	18-Apr-00	Received via fax
	Professional / Regulatory	College of Nurses of Ontario and Registered Nurses Association of Ontario - co-submission	Gayle Makay, Interim Executive Director, CNO, Doris Grinspun, Executive Director, RNAO	18-Apr-00	Received via e-mail
		Registered Practical Nurses Association of Ontario	Barbara Thomber, Executive Director, 5025 Orbitor Dr. Building 4, Suite 200, Mississauga ON L4W 4Y5	14-Apr-00	Received via fax
	Educators	University of Windsor, School of Nursing	Dr. Beth Horsburgh, Director School of Nursing, University of Windsor, 401 Sunset, Windsor ON N9B 3P4	11-Apr-00	Received via fax
		Deans of Nursing , Ontario Colleges of Applied Arts and Technology	Micki Walters	20-Apr-00	Received via e-mail
		University of Toronto, School of Nursing	Gail Donner, Dean Faculty of Nursing, dean.nursing@utoronto.ca	April 13. 2000	Received via e-mail
	Employers	Ontario Long-term Care Association	Vida Vaitonis, Executive Director	25-Apr-00	Received via fax
	Other				
Quebec	Labour				
	Professional / Regulatory				
	Educators				
	Employers				
	Other				

New Brunswick	Labour	New Brunswick Nurses Union	Linda Silas, President, mbye@nbnet.nb.ca	14-Apr-00	Received via e-mail - also being sent via mail
	Professional / Regulatory	Nurses Association of New Brunswick	Lucille M. Auffrey	5-May-00	Received via mail
		Association of New Brunswick Registered Nursing Assistants	Normand L. McDonald, Executive Director-Registrar, 384 rue Smythe St. Fredericton, NB E3B 3E4	18-Apr-00	Received via mail
	Educators				
	Employers	New Brunswick Association of Nursing Homes	Rachel Clair, Executive Director rclair@health.nb.ca	3-Apr-00	Received via e-mail
	Other	Nursing Resources Advisory Committee	Barbara McGill, Chair, NRAC, 20 Maplecrest Dr. Saint John, NB E2H 1K3	17-Apr-00	Received via e-mail
Nova Scotia	Labour	Nova Scotia Nurses' Union	Heather Henderson, President 65 Queen St Dartmouth, NS B2Y 1G4	18-Apr-00	Received via fax
		Nova Scotia Association of Health Organizations	2 Dartmouth Rd, Bedford, NS B4A 2K7	25-Apr-00	Received via e-mail
		Nova Scotia Government Employees Union	Joan Jessome, President	25-Apr-00	Received via e-mail
	Professional / Regulatory	Licensed Practical Nurses Association of NS	Albert MacIntyre, Executive Director, Ann Mann, Executive Director/ Registrar	25-Apr-00	Received via mail
		Registered Nurses' Association of Nova Scotia	Carolyn Moore, Executive Director, Suite 600 Barrington Tower, Scotia Square, 1894 Barrington St. Halifax, NS B3J 2A8	17-Apr-00	Received via mail
	Educators	Department of Nursing St. Francis Xavier University	Jean MacInnis, Antigonish Nova Scotia jmacinni@stfx.ca	11-Apr-00	Received via e-mail
		School of Nursing, Faculty of Health Professions and the Population Health Research Unit, Community Health and Epidemiology, Dalhousie University	Gail Tomblin Murphy, Jean Hughes, Mike Pennock	1-May-00	Received via e-mail
		Dalhousie University, School of Nursing	Barbara Downe-Wamboldt, Director, Halifax, NS B3H 3J5	14-Apr-00	Received via fax
	Employers	The Nova Scotia Hospital	Anne McGuire, Executive Director, 300 Pleasant St. PO Box 1004, Dartmouth, NS B2Y 3Z9	17-Apr-00	Received via mail
		Eastern Regional Health Board	John Higgins, CEO - 65 Memorial Dr. PO Box 37, North Sydney, NS B2A 3S8 tel: 902-794-6010	7-Apr-00	Received via mail
		Queen Elizabeth II Health Sciences Centre	Office of the VP Clinical Services, 1796 Summer St, Halifax NS B3H 3A7	25-Apr-00	Received via mail

		Northern Regional Health Board	Brenda Payne, RN,BN, MN, Executive Director, Patient Care Services, Northern Regional Health Board, hnrhb@nrhb.ns.ca	14-Apr-00	Received via e-mail
	Other				
Newfoundland	Labour	Newfoundland and Labrador Nurses' Union	Debbie Forward, President	25-Apr-00	Received via e-mail
	Professional / Regulatory	Council for Licensed Practical Nurses	Paul D. Fisher, Executive Director	28-Apr-00	Received via fax
		Association of Registered Nurses of Newfoundland and Labrador	Jeannette Andrews, jandrews@nf.aibn.com	11-Apr-00	Received via e-mail
	Educators	Memorial University of Newfoundland	Dr. Carole Orchard, Director and Associate Professor, School of Nursing, St. John's NF A1B 3V6	11-Apr-00	Received via mail
		College of the North Atlantic	Pamela Walsh, President, 432 Massachusetts Dr. PO Box 5400 Stephenville, NF A2N 2Z6	11-Apr-00	Received via mail
	Employers	Health and Community Services Western Regions	Marq Burden for Marilyn Fleming	14-Apr-00	Received via fax
		Central West Health Corporation	David Diamond, Chief Operating Officer and VP of Human Resources	1-May-00	Received via mail
	Other	Government of Newfoundland & Labrador	Florence Delaney, DM Health and Community Services, Department of Education	13-Apr-00	deferred response to Memorial University's School of Nursing - Dr. Carole Orchard , Director
		Centre For Nursing Studies	Jean Rowsell, Director, Centre for Nursing Studies	9-May-00	Received via fax
		Gillian Kennedy	Former President of the Nursing Society of Memorial University, student rep on the RN/LPN Human Resources Planning Sub-Committee with the Department of Health and Community Services	14-Apr-00	Received via fax
Prince Edward Island	Labour	PEI Union of Public Employees	Barb Boudreau, Chairperson, PEIUPSE Health Care Committee	14-Apr-00	Received via e-mail
	Professional / Regulatory	Licensed Nursing Assistant Association of PEI	P.O Box 1254 Charlottetown , PE C1A 7M8	14-Apr-00	Received via fax
		PEI Nursing Assistants Registration Board	Genevieve Poole, Registrar, Box 3235 Charlottetown PE C1A 7N9	14-Apr-00	Received via fax
		Association of Nurses of PEI	Becky Gosbee, Executive Director / Registrar	17-Apr-00	Received via fax
	Educators	PEI Department of Education	Ms. Elaine Noonan, DM of Education	25-Apr-00	Received via fax
	Employers	Southern Kings Health, PEI Health & community Service System	Betty Fraser, CEO, 35 Douses Rd, P.O. Box 3000 Montague PE C0A 1R0	13-Apr-00	Received via mail

	Other	The Medical Society of PEI	Marilyn Lowther, CHE Executive Director	25-Apr-00	Received via mail
Nunavut	Labour				
	Professional / Regulatory				
	Educators				
	Employers				
	Other				
Northwest Territories	Labour				
	Professional / Regulatory				
	Educators				
	Employers				
	Other	Nursing Stakeholders in the NWT	Stanton Regional Health Board, GNWT Department of Health and Social Services, Aurora College, Stanton Regional Health Board, NWTRNA, Inuvik Regional Health & Social Services Board, NT Certified Nursing Assistant Association	18-Apr-00	Received via e-mail
Yukon	Labour				
	Professional / Regulatory	Yukon Registered Nurses Association	Catherine Bradbury, President Suite 14, 1114-1st Ave Whitehorse, YK Y1A 1A3	14-Apr-00	Received via fax
	Educators	Yukon College		25-Apr-00	Received via e-mail
	Employers	Whitehorse General Hospital - Operated by Yukon Hospital Corporation	Ron Browne, CEO, 5 Hospital Rd, Whitehorse, YK Y1A 3H7	11-Apr-00	Received via e-mail
	Other	Department of Health and Social Services Government of Yukon	Joanne Fairlie, ADM	14-Apr-00	Received via fax
Federal	Labour	Professional Institute of the Public Service of Canada	Marg McCoy, PIPSC Vice-President	28-Apr-00	Received via mail
	Professional / Regulatory	Canadian Practical Nurses Association	Kelly Kay, Executive Director, 14-4218 Lawrence Avenue East #271, Scarborough, ON M1E 4X9	14-Apr-00	Received via e-mail - sent follow-up e-mail on April 25, 2000
		Canadian Nurses Association	Mary Ellen Jeans, RN, PhD, Executive Director	14-Apr-00	Received via e-mail, courier copy coming
	Educators	Canadian Association of University Schools of Nursing	Lynne Young	20-Apr-00	Recevied via e-mail

		Canadian Nursing Students Association	Melanie Dyke, President	20-Apr-00	Received via fax
		Canadian Nursing Students Association	Sean McIntyre (past vice - president) for Catherine Forbes (Vice-President Education Research Director), 3777 chemin St. Louis, Ste. Foy, QC G1W 1T6	14-Apr-00	Received via e-mail
	Employers				
	Other	Office of Rural Health, Health Canada	Judith Dowler, Health Promotion and Programs Branch	25-Apr-00	Received via e-mail
		Catholic Health Association of Canada	Richard Haughian. President	4-May-00	Received via e-mail
		HRDC	Ron Stewart	1-May-00	Received via mail - referred strategy to the Human Resources Partnerships Directorate - Sectoral Occupational Studies Division
		Canadian Healthcare Association	Kathryn Tregunna, Director, Policy Development	20-Apr-00	Received via e-mail

APPENDIX B
SUMMARY OF CONSULTATION RESPONSES

A stakeholder consultation document, *Towards a Nursing Strategy for Canada,* was released by the Federal/Provincial/Territorial Working Group on Nursing Resources (WGNR), a sub-committee of the Advisory Committee on Health Human Resources (ACCHR) in March, 2000. The purpose of this document was to solicit advice and feedback from the many nursing workforce stakeholders prior to developing a nursing strategy for Canada. This consultation paper began by exploring the perspectives on nursing workforce issues held by the many stakeholders in order to establish a common understanding of the complexity of this issue. It also posed twelve action strategies, developed by the WGNR, for consideration. Ninety-four formal responses were received by the WGNR. These responses confirmed that while there are many perspectives on this issue, there is a unified view that nursing is in crisis and there is a need for immediate and proactive action on the part of all stakeholders.

Accordingly, there was wide support for the development of a unifying multi-stakeholder Canada-wide advisory committee to address the most pressing nursing workforce issues and to provide support for provinces and territories as they address these issues within their respective jurisdictions. As well, there was support for the development of similar bodies in those jurisdictions where such integrated planning and policy development does not already occur. Stakeholders throughout the health care system recognized the need to increase and improve nurse workforce planning. To do so, there was support for the collection of more comprehensive data on nursing groups. As well, there was support for ensuring a strong and coordinated national research agenda to ensure evidence on which to develop needed policy.

While the provincial/territorial jurisdiction over health and education was recognized, there was also support for the federal government to take a lead role in the development of improved health human resource to establish improved future projections for nursing supply and demand. Many respondents noted that it was time to expand beyond the simple supply models that have guided health human resource planning to date.

While there was strong support for increases to education and training capacity for all three nursing groups, the majority of respondents suggested that the recommended 10 percent increase across Canada in registered nursing seats over two years may be too conservative. Many respondents also commented that increases to nursing education capacity should be determined through improved human resource planning that includes the full spectrum of nursing practice and takes changes in health care practice, population health and demographics into consideration. There was a strong message from the

associations representing licensed practical nurses and registered psychiatric nurses that these planning activities need to be inclusive of their members.

Many respondents also emphasized the need to ensure that this increased nursing school capacity be supported by adequate clinical placements and that both post-grad support and full-time employment be ensured for these new graduates in order to retain them in the profession and within the health system.

Registered nursing professional regulatory bodies and many groups representing registered nurses offered strong support for the introduction of the new competencies. However, there were also concerns expressed that the impact of the introduction of these polices must be assessed and care taken to avoid unintentional short-term reductions of registered nurses. Also, it was emphasized that the educational needs of the existing workforce must be addressed, particularly for continuing education to increase competencies and for specialty training.

While the professional regulatory bodies expressed the need to respect their statutory responsibility for scope of practice and competencies, there was strong support for the need to examine the full spectrum of nursing practice. It was widely recognized that all nurses should be utilized to the fullest extent of their competencies to meet the health needs of the public and that there is a need to determine optimal nurse-mix and use of non-nursing personnel.

Many stakeholders suggested that solutions to the current shortage of nurses need to be both pragmatic and innovative. Even with concerted efforts, the social, demographic and fiscal realities of this new century are resulting in a major structural change to the nursing workforce that cannot be resolved by traditional supply strategies. Accordingly, many respondents emphasized the need for better management of the current workforce. Many jurisdictions report serious difficulties in recruiting nurses, although their individual needs range widely, from casual to specialty trained nurses. Retention of nurses, both in positions and in the profession itself was also identified as serious problem.

Improving the quality of the work life of nurses was identified repeatedly as key in addressing these issues. Improving the quality of the work life has many different aspects, and given the diversity of the nursing workforce there is no single solution. However, strong support was offered for increased continuing education that includes portability and laddering opportunities, flexible scheduling, increased nursing management leadership and support at the clinical level, improved nurse/patient ratios to address workload concerns, reduction in non-nursing duties, and reduced 'casualization'.

Finally, there was a call for action: there is a strong belief that the current shortages in nursing and the dissatisfaction of nurses will not improve without quick and decisive and unified action from policy makers and funders.

APPENDIX C
THE NURSING WORKFORCE STUDY:
CHANGES IN THE NURSING WORKFORCE AND POLICY IMPLICATIONS
SYNOPSIS

This study was commissioned by the Federal/Provincial/Territorial Advisory Committee on Health Human Resources (ACHHR) to develop baseline data on the supply and education of RNs, RPNs, and LPNs, and on employer practices pertaining to the deployment of all patient care providers.

The first part of the study "Demographic Context and Health System Structure for Nursing Services in Canada," provides a general overview of demographic and system changes; it describes the current demographic context for nursing practice and the structure of provincial/territorial health care delivery systems. The demographic analyses are based on 1996 Census data. Provincial/territorial health care delivery information for the most part are obtained from "Health System Reform in Canada, 1997," by Health Canada.

Next, "The Supply of Nursing Personnel in Canada" examines data on the supply of nursing personnel in the provinces and territories to provide basic information about employment status, deployment (place of employment, area of responsibility, type of position, hours worked), age and type and place of education/training. The analysis is based on data collected by the respective regulatory bodies in their registration and renewal processes. Two separate years of secondary data are utilized in the analysis (1990 and 1997), presenting a detailed national and regional picture on the supply of nurses in Canada.

The third part of this study "An Inventory of Nursing Program Enrolments and Graduates in Canada by Province/Territory, 1998" describes the production of nursing personnel in Canada. A survey questionnaire was sent to provincial/ territorial representatives (usually the education representative) of the ACHHR who were asked to complete the survey for all nursing education programs in their jurisdictions. The questionnaire requested information as to the type of credential offered, the length of the program, the number enrolled in each year of the program, the number of students enrolled full-time, part-time, or in distance education and the number of graduates in 1997 and 1998. The analysis includes the impact of BN-only basic education for RNs.

"Nursing Workforce Deployment: A Survey of Employers" examines employer practices and policies for nursing workforce deployment in each province/ territory. A sample survey regarding deployment was undertaken using a questionnaire pertaining to all 3 regulated nursing groups: LPNs, also known as Registered Nursing Assistants (RNAs), RPNs, and RNs. Information on other professionals and unregulated patient care providers, (e.g. aides) was also

collected by the questionnaire. The questionnaire was designed to capture the following information: hiring practices (amount of experience required, deployment, credentials, etc.), kinds of services provided and the skills perceived to be needed to provide those services, numbers and mix of nursing personnel used to provide services, use of unregulated health care workers in relation to nursing services provision, and anticipated changes in deployment practices related to changes in the organization of the health care delivery system.

"Policy Issues in Nursing Workforce Supply and Deployment" the final part of the study, synthesizes the findings from each of the above sections and attempts to delineate the salient policy issues.

Two types of data limitations have circumscribed the breadth and depth of the analyses. On the supply side, data on RNs obtained through CIHI and historically through statistics Canada are not uniform across time and jurisdiction. The problem of incomplete data from some jurisdictions is compounded by data access stipulations by the data stewards: information exists which was not made available to the study, limiting researcher capacity to undertake longitudinal analyses. Severely hampering a fuller examination of nursing workforce issues, databases on LPNs or RNAs and RPNs are not standardized and very sketchy. Incomplete survey returns pose limitations on education data.

Regarding data on deployment, limitations pertaining to sample surveys apply. In addition, limitations posed by a changing system structure in the proper definition of the survey universe may curtail the ability to generalize the findings.

APPENDIX D
SUMMARY OF STRATEGIES FOR CHANGE

STRATEGY 1

The federal government and provincial/territorial governments immediately establish a multi-stakeholder Canadian Nursing Advisory Committee (CNAC) to address priority issues as identified by the Advisory Committee on Health Human Resources (ACHHR) and the Working Group on Nursing Resources and Unregulated Health Care Workers (WGNR). The key focus for CNAC for 2000/01 will be improving the quality of work life for nurses and providing advice to support the implementation of other strategies of the Nursing Strategy for Canada.

STRATEGY 2

A Nursing Advisory Committee (NAC) be established (where an equivalent body does not exist) by each province and territory to support the development of strategies for improved nurse human resource planning and management within each jurisdiction.

STRATEGY 3

The federal/provincial/territorial governments encourage the efforts of the Canadian Institute for Health Information (CIHI) and other organizations to develop the information required for the effective planning and evaluation of nursing resources.

STRATEGY 4

The ACHHR work with major research funders to identify gaps in current research, to profile workforce planning issues for new research funding, and recommend improved mechanisms for the dissemination of these research results to policy makers and managers.

STRATEGY 5

The federal government provide leadership to ensure the development of improved projections for nursing supply/demand requirements to the year 2015.

STRATEGY 6

A communications strategy be developed with the goal of increasing the public's awareness of nursing as a positive career choice and increasing the number of qualified applicants to nursing schools.

STRATEGY 7

The number of nursing education seats be increased Canada-wide by at least 10 percent over 1998/99 levels over the next 2 years (2000/2002), and increases in following years be based upon improved demand projections and provincial/territorial need and capability.

STRATEGY 8

Each provincial/territorial NAC or equivalent body develop a comprehensive strategy to determine what types of nursing human resources are required and for which practice settings, based on an analysis of the needs of the population, of the health system as a whole, and the skills and capacities of all types of nurses.

STRATEGY 9

Each provincial/territorial NACs or equivalent body develop a five-year provincial/territorial Nursing Education Plan based on the comprehensive strategy proposed in Strategy 8.

STRATEGY 10

Provincial/territorial NACs (or equivalent body) identify and support the implementation of retention strategies for their respective workforces that focus on improving the quality of the work lives of nurses.

STRATEGY 11

Provincial/territorial NACs (or equivalent body) examine opportunities to encourage nurses to re-enter the workforce.